

Monthly Reporting Instructions

To understand your level of participation in the Evidence Based Treatment Dissemination Center (EBTDC) and the opportunities you have to administer the treatments, we are asking you to complete the EBTDC Monthly Reporting Form. Each month all EBTDC participants (clinicians, supervisors, and supervisor/clinicians) will be required to report on the consultation received and/or clinical implementation of the two evidence-based treatments.

To successfully complete EBTDC and receive a certificate you must submit nine monthly reports. Each report is due on the 7th of the following month.

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Detailed Instructions

To access the EBTDc Monthly Reporting Form, go to the following web page (it is a good idea to bookmark this page or save it in your favorites):

http://clinicplus.omh.ny.gov/EBTDC/EBTDC_PAGE1.aspx

You may save your data at any time by clicking on "Save" at the bottom left of the screen.

Select Program Identifier:

- Provider OMH Operating Certificate # (day treatment or clinics)-if you do not know your operating certificate #, please ask your program director.
- Facility ID (State-operated inpatient programs)
- Unique ID assigned by OMH (Other Programs):

Fill in the corresponding number for your program.

Click "Search" to reveal the Monthly Reporting Form, items 1 through 4.

Monthly Reporting Form, Items 1-4

1. To begin, please input the following information:

Provider OMH Outpatient Operating Certificate #

Facility ID

Unique ID

| | |
|---------------|------------------------------------|
| Unique Number | 8888 |
| Name | TEST AGENCY |
| Address | 44 Holland Ave Albany, NY 12229 |

2. Select Clinician

| | | |
|---------------------|---------------|------------------|
| 8890 - Jane Doe | Contact Phone | (518) 888 - 8888 |
| 8891 - Jackie Smith | Contact Email | JaneDoe@mail.com |

3a. Clinician call group 2A 3b. Supervisor call group

4. Report Month 2009-December

Item 1

Indicates the number you entered on the previous screen. No entry is needed here.

Item 2

Select your name from the drop down list.

Item 3

Indicates your call group numbers. No entry is needed here.

Item 4

Select the month you are reporting on.

Click "View/Edit Monthly Report" to reveal the next page of the form.

Monthly Reporting Form, Items 6 through 10

EBTDC

http://clinicplus.dev.omh.state.ny.us/EBTDC/EBTDC_PAGE2.aspx?M_USER_ID=...

New York State
Office of Mental Health
Clinic Plus EBTDC

EBTDC Information Reporting Form

| | | | | | | | |
|--------------|------|----------------------|----|-----------------------|--|--------------|---------|
| Clinician ID | 8890 | Clinician Call Group | 2A | Supervisor Call Group | | Report Month | 12/2009 |
|--------------|------|----------------------|----|-----------------------|--|--------------|---------|

6. Number of Bi-weekly EBTDC Clinician Consultation Calls attended this month: 2

7. Number of Monthly EBTDC Supervision Consultation Calls attended this month: 0

8. Date Cases were presented on Consultation Calls this month:

| | |
|-------------------------|------------|
| 8a. Case 1 (mm/dd/yyyy) | 11/10/2009 |
| 8b. Case 2 (mm/dd/yyyy) | |

9. Number of Internal Supervision sessions through your agency received this month. (This includes individual, group or peer supervision with EBTDC cases and guidance on DBD components/skills that you received through your agency. Do not include consultation received from your EBTDC Consultant.) 1

10. CHECK the Box if you DID NOT Assess or Treat EBTDC cases this month. If CHECKED - You do not need to complete the remainder of this form. You are finished!

| Delete | 11. Child Selected ID | 12. EBTDC Assessment Protocol | 13. # of Sessions provided to Parent | 14. # of Coping Sessions provided to Youth | 15. # of Parent Mgt Sessions provided to Caregiver | 16. Treatment Status as of the end of the reporting month. | 17. Child and/or family goals met. | 18. Pre-DBD Tmt SNAP Score-ODD Total | 19. Pre-DBD Tmt SNAP Score-ADHD H/M Total | 20. Date of Pre-DBD Treatment (mm/dd/yyyy) | 21. Post-DBD Tmt SNAP Score-ODD Total | 22. Post-DBD Tmt SNAP Score-ADHD H/M Total | 23. Date of Post-DBD Treatment (mm/dd/yyyy) | 24. Total # Treatment Sessions (Approximate # of sessions completed over the course of treatment). |
|--------|-----------------------|-------------------------------|--------------------------------------|--|--|--|------------------------------------|--------------------------------------|---|--|---------------------------------------|--|---|--|
| 1 | | | | | | | | | | | | | | |

Enter client information

Save Mark data as completed. (No more changes will be allowed.) Home

Item 6

Enter the number of clinical consultation calls attended.

- If you are a **supervisor** and did not participate in any clinician calls, enter 0.
- If you are a **supervisor/clinician**, enter the number of clinician calls only in which you participated.

Item 7

Enter the number of supervisor consultation calls.

- If you are a clinician and did not participate in any supervisor calls, enter 0.
- If you are a **supervisor/clinician**, enter the number of supervisor calls only in which you participated.

Item 8

Enter the date(s) on which you **formally** presented a case on a clinician or supervisor consultation call.

Item 9

Enter the number of **internal** supervision sessions received through your agency during the reporting month. This includes individual, group or peer supervision sessions that you received within your agency. Include only those supervision sessions that focused on the EBTDC cases, manuals or skills. Please do **not** include phone consultation with the Columbia consultants.

Item 10

If you did not assess or treat any EBTDC children or caregivers during the reporting month, check this box. (Supervisors will check this box most months.) Proceed to **“Saving and Submitting the Report.”** **Otherwise, please proceed to item 11.**

You may save your data at any time by clicking on “Save” at the bottom left of the screen.

Monthly Reporting Form, Items 11 through 16

EBTDC

http://clinicplus.dev.omh.state.ny.us/EBTDC/EBTDC_PAGE2.aspx?M_USER_ID=890&YR=2009&MC

New York State Office of Mental Health

EBTDC Information Reporting Form

Clinician ID: 0890 Supervisor Call Group: 2A Report Month: 12/2009

6. Number of Bi-weekly EBTD Clinician Consultation Calls attended this month: 2

7. Number of Monthly EBTD Supervision Consultation Calls attended this month: 0

8. Date Cases were presented on Consultation Calls this month:

8a. Case 1 (mm/dd/yyyy): 11/10/2009

8b. Case 2 (mm/dd/yyyy):

9. Number of Internal Supervision sessions through your agency received this month. (This includes individual, group or peer supervision with EBTD cases and guidance on DBD components/skills that you received through your agency. Do not include consultation received from your EBTD Consultant.): 1

10. CHECK the Box if you DID NOT Assess or Treat EBTD cases this month, if CHECKED - You do not need to complete the remainder of this form. You are finished!

| Delete | 11. Child ID # | 12. Select EBTD Protocol | 13. # of Assessment Sessions | 14. # of Coping Power Sessions | 15. # of Parent Mgt Sessions provided to Youth Caregiver | 16. Treatment Status at the end of the reporting month. | 17. Child and/or family goals met. | 18. Pre-Treat DBD Total | 19. Post-Treat DBD Total | 20. Date of Pre-Treat SNAP Score (mm/dd/yyyy) | 21. Post-Treat SNAP Score (mm/dd/yyyy) | 22. Date of Post-Treat DBD ADHM Total | 23. Date of Post-Treat SNAP Score (mm/dd/yyyy) | 24. Total # of Treatment Sessions (Approximate # of sessions completed over the course of treatment) |
|--------|----------------|---------------------------|------------------------------|--------------------------------|--|---|------------------------------------|-------------------------|--------------------------|---|--|---------------------------------------|--|--|
| X | 12345 | Coping Power/Parent Mgmt. | 1 | 2 | 2 | Continuing | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |

Enter client information

Save Mark data as completed. (No more changes will be allowed.) Home

Complete the next section only if you assessed or treated a child or caregiver during the reporting month.

Click "Enter client information" located below the item 11-24 grid. This will create a line for you to report on each child and caregiver.

Item 11

For each child assessed or treated in the reporting month, including the parent education program, enter a unique identifier such as your internal child identification number or child 1, child 2. Do not include the child's name.

Item 12

From the drop down list, select the modality used with this client.

Items 13, 14, and 15

Please select the number of sessions during which you provided assessment, Coping Power and/or Parent Management Training in the reporting month.

- If this child received an assessment over the course of 3 days (11/27/09, 12/02/09 and 12/05/09), you would indicate select 1 in item 13 in the November report and 2 in item 13 in the December report.

Item 16

Select the treatment status from the drop down list.

- Continuing: you expect to see this child or caregiver for additional sessions. **Please see ["Saving and Submitting the Report."](#)**
- Dropped Out: the child and/or caregiver has discontinued either Coping Power and/or Parent Management training. This child may still be receiving other services at your agency. **Please see ["Saving and Submitting the Report."](#)**
- Completed: the child and/or caregiver has completed the selected DBD treatment modality though s/he may be receiving other services at your agency. **Proceed to items 17 through 22.**

If you worked with additional EBTD clients this month, please select "Enter client information" once again. This will create a new line for client information. Continue to follow this procedure for every EBTD client. When you have entered all your EBTD clients, **please follow instructions ["Saving and Submitting the Report."](#)**

You may save your data at any time by clicking on "Save" at the bottom left of the screen.

Monthly Reporting Form, Items 17 through 24

Complete the next section only when a child or caregiver has completed DBD treatment.

EBTDC Information Reporting Form

Clinician ID: 0890 Clinician Call Group: 2A Supervisor Call Group: Report Month: 12/2009

6. Number of Bi-weekly EBTDC Clinician Consultation Calls attended this month: 2

7. Number of Monthly EBTDC Supervision Consultation Calls attended this month: 0

8. Date Cases were presented on Consultation Calls this month:

8a. Case 1 (mm/dd/yyyy): 11/10/2009

8b. Case 2 (mm/dd/yyyy):

9. Number of Internal Supervision sessions through your agency received this month. (This includes individual, group or peer supervision with EBTDC cases and guidance on DBD components/skills that you received through your agency. Do not include consultation received from your EBTDC Consultant): 1

10. CHECK the box if you DID NOT Assess or Treat EBTDC cases this month. If CHECKED - You do not need to complete the remainder of this form. You are finished!

| Client ID | Child ID | Select EBTDC Protocol | # Assessment Sessions | # Coping Power Sessions | # Parent Mgmt Sessions | Treatment Status as of the end of the reporting month. | Child and/or family goals met. | Pre-DBD SNAP Score-ODD Total | Pre-DBD SNAP Score-H/IM Total | Date of Pre-DBD Treatment (mm/dd/yyyy) | Post-DBD SNAP Score-ODD Total | Post-DBD SNAP Score-H/IM Total | Date of Post-DBD Treatment (mm/dd/yyyy) | Total # Treatment Sessions (Approximate # of sessions completed over the course of treatment) |
|-----------|----------|---------------------------|-----------------------|-------------------------|------------------------|--|--------------------------------|------------------------------|-------------------------------|--|-------------------------------|--------------------------------|---|---|
| X | 12345 | Coping Power/Parent Mgmt. | 1 | 2 | 2 | Continuing | | 0 | 0 | | 0 | 0 | | |
| X | 23456 | Coping Power/Parent Mgmt. | 0 | 3 | 3 | Completed | All | 17 | 15 | 9/15/2009 | 15 | 13 | 11/29/2009 | 11-20 |

Enter client information

Save Mark data as completed. (No more changes will be allowed.) Home

Complete the next section only if you assessed or treated a child or caregiver during the reporting month.

Item 17

Indicate whether the child and family met all, some or none of their goals.

Item 18 and 19

Enter the pre-DBD treatment SNAP (Swanson, Nolan and Pelham) scores, ODD (Oppositional/Defiant Disorder) total and H/IM (Hyperactivity and Impulsivity) total, respectively.

Item 20

Enter the date you administered the **pre**-DBD treatment SNAP even if it is not during the reporting month.

Item 21 and 22

Enter the **post**-DBD treatment SNAP scores.

Item 23

Enter the date you administered the post-DBD treatment SNAP.

Item 24

From the drop down list, select the approximate number of sessions provided to this child and/or family over the course of the treatment.

- If a child received Coping Power and her/his caregiver received Parent Management, add the number of Coping Power and Parent Management sessions together for the total number of sessions.

If you worked with additional EBTDC clients this month, select "Enter client information" once again. Continue to follow this procedure for every EBTDC client. When you have entered all your EBTDC clients, **please follow instructions** "[Saving and Submitting the Report.](#)"

You may save your data at any time by clicking on "Save" at the bottom left of the screen.

Saving and Submitting the Report

EBTDC

http://clinicplus.dev.omh.state.ny.us/EBTDC/EBTDC_PAGE2.aspx?M_USER_ID=891&YR=2009&MC

New York State
Office of Mental Health
Clinic Plus EBTDC

EBTDC Information Reporting Form

Clinician ID 8691 Clinician Call Group 2A Supervisor Call Group S2 Report Month 11/2009

6. Number of Bi-weekly EBTDC Clinician Consultation Calls attended this month: 2

7. Number of Monthly EBTDC Supervision Consultation Calls attended this month: 1

8. Date Cases were presented on Consultation Calls this month:

8a. Case 1 (mm/dd/yyyy)

8b. Case 2 (mm/dd/yyyy)

9. Number of Internal Supervision sessions through your agency received this month. (This includes individual, group or peer supervision with EBTDC cases and guidance on DBD components/skills that you received through your agency. Do not include consultation received from your EBTDC Consultant.) 2

10. CHECK the box if you DID NOT Assess or Treat EBTDC cases this month. If CHECKED - You do not need to complete the remainder of this form. You are finished!

| 11. Child ID | 12. Select EBTDC Protocol | 13. # Assessment Sessions | 14. # Coping Power Sessions | 15. # of Parent Mgt Sessions provided to Youth Caregiver | 16. Treatment Status as of the end of the reporting month. | 17. Child and/or family goals met. | 18. Pre-DBD SNAP Score-ODD Total | 19. Post-DBD SNAP Score-ADHD Total | 20. Date of Pre-DBD Treatment (mm/dd/yyyy) | 21. Post-DBD SNAP Score-ODD Total | 22. Post-DBD SNAP Score-ADHD Total | 23. Date of Post-DBD Treatment (mm/dd/yyyy) | 24. Total # Treatment Sessions (Approximate # of sessions completed over the course of treatment). |
|--------------|---------------------------|---------------------------|-----------------------------|--|--|------------------------------------|----------------------------------|------------------------------------|--|-----------------------------------|------------------------------------|---|--|
| X 34567 | Coping Power | 0 | 4 | 0 | Completed | All | 16 | 14 | 8/28/2009 | 14 | 12 | 11/30/2009 | 11-20 |

Enter client information

Save Mark data as completed. (No more changes will be allowed.) Home

If you are **not** finished entering this month's information, you may click "Enter client information" to report on another child or caregiver. If you do not wish to continue filling out the form at this time, click "Save" to retain your entries. You may exit the report and return at another time to make additions, deletions and/or revisions.

You may save your data at any time by clicking on "Save" at the bottom left of the screen.

If the information is **correct and complete** for the reporting month, click both "Mark Data as complete" and also "Save." This will submit the report. **You will not be able to make further changes to this report.**

Return to item by item guidelines:

[Items 6-10](#)

[Items 11-16](#)

[Items 17-24](#)

The [Monthly Reporting Tracking Form](#) was designed to assist you tracking your clients throughout the month.

Questions

Please [contact the Evidence Based Treatment Dissemination Center staff](#).